Department of Corrections
WASHINGTON STATE

# CHEMICAL DEPENDENCY/MENTAL HEALTH/ CRIMINAL JUSTICE SYSTEM MULTI-PARTY AUTHORIZATION FOR RELEASE OF INFORMATION

## Consent for the Release of Confidential Information about Mental Health and Alcohol or Drug Treatment

**I,** _____ **authorize (1) The Department of Corrections**

**and**

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| **(2) the following Mental Health Treatment Provider:**<br>***Name:*** _____<br>***Address:*** _____<br>***Phone Number:*** _____ | **(3) the following Alcohol or Drug Treatment Provider:**<br>***Name:*** _____<br>***Address:*** _____<br>***Phone Number:*** _____ |
| **(4) the following Designated Chemical Dependency Specialist (DCDS):**<br>***Name:*** _____<br>***Address:*** _____<br>***Phone Number:*** _____ | **(5) the following other provider of information necessary for cross-systems communication:**<br>***Name:*** _____<br>***Address:*** _____<br>***Phone Number:*** _____ |

**To communicate with and disclose to one another the following information** (The client must initial each type of information authorized)**:**

**(1) Department of Corrections**
- ☐ Pre-Sentence Investigation
- ☐ Judgment and Sentence
- ☐ Criminal History
- ☐ Risk Assessment
- ☐ Compliance with Supervision
- ☐ Conditions of Supervision
- ☐ Mental Health Assessments
- ☐ Violations of Terms of a Court Ordered Treatment

**(2) Mental Health Treatment**
- ☐ MH Treatment Discharge Summaries
- ☐ MH Treatment History and Progress Reports
- ☐ Involuntary Treatment History/Records (RCW 71.05)
- ☐ MH Intake and Treatment Plans
- ☐ Psychological Evaluations
- ☐ Psychiatric Evaluations
- ☐ Forensic Discharge Review (State Hospital)
- ☐ MH Treatment Discharge Summaries

**(3) Chemical Dependency/Substance Abuse Treatment**
- ☐ Chemical Dependency Assessments and Treatment Plans
- ☐ CD Treatment History and Progress Reports
- ☐ CD Treatment Discharge Summaries
- ☐ CD Treatment Continuing Care Plan
- ☐ Treatment Compliance Reports (Requested by DOC)
- ☐ Request to Designated Chemical Dependency Specialist (DCDS) for an Assessment
- ☐ Chemical Dependency Assessments and Treatment Plans
- ☐ Involuntary Treatment History/Records (RCW 70.96 A)

**(4) Designated Chemical Dependency Specialist (DCDS)**
- ☐ Violations of a Treatment Order or Condition of Supervision that relates to Public Safety
- ☐ Information about a Petition for Involuntary Commitment

**(5) Other:** Specify other information as necessary for cross-systems collaboration:
- ☐ _____

**The purpose of the disclosures authorized in this consent is:**

**(1) To improve public safety by allowing communication and multidisciplinary case management and release planning.**

**(2) To enable treatment providers to communicate continuing care plan referrals to the above agencies**

I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 Code of Federal Regulations (CFR) Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR, Parts 160 and 164. I understand that this authorization shall remain in effect for the duration of my DOC supervision unless revoked prior to that time. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

☐ There has been a formal and effective termination or revocation of my release from confinement, probation, or parole, or other proceeding under which I was mandated to treatment, or

☐ _____

(Specify other time when consent can be revoked and/or expires)

I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

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|---|---|
| **Signature of Offender/Client:** | **Initials:** **Date:** |
| **DOC Number:** | **Date of Birth:** |
| **Co-signature of Parent/Guardian if Offender/Client is under the age of 18** | |

The records contained herein are protected by Federal Confidentiality Regulations 42 CFR Part 2 and 45 CFR Parts 160 and 164. The Federal rules prohibit further disclosure of this information to parties outside of the Department of Corrections unless such disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.